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In the Supreme Court of the United States

OCTOBER TERM, 1986

BETHESDA HOSPITAL ASSOCIATION AND
THE DEACONESS HOSPITAL OF CINCINNATI, OHIO,
PETITIONERS,

v.

OTIS R. BOWEN, M.D., SECRETARY
OF HEALTH AND HUMAN SERVICES,
RESPONDENT.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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QUESTION PRESENTED FOR REVIEW

A Medicare provider (*e.g.*, a hospital) must file a cost report with its fiscal intermediary at the end of each year. The fiscal intermediary audits the cost report and issues a Notice of Program Reimbursement (NPR) indicating the total amount of Medicare reimbursement due the provider for the year. A provider may appeal to the Provider Reimbursement Review Board if it is dissatisfied with the amount of reimbursement as indicated in its NPR. The Secretary has interpreted the Medicare statute to require that, in order for a provider to challenge one of the Medicare regulations, the provider must claim costs expressly stated to be non-allowable under that regulation when filing its cost report.

The question presented for review, as to which the Courts of Appeal are in conflict, is:

Whether the Secretary's informal interpretation described above can be the basis for denying a provider access to the administrative and judicial process where: (1) the Medicare statute on its face does not impose such a requirement; (2) neither the statute nor the regulations provide notice that filing a cost report in compliance with the regulations operates as a waiver of any right to be heard; and (3) the intermediary cannot invalidate the regulation in order to allow the costs?

A necessary subquestion is whether the courts' construction of the Medicare statute to deny a right to be heard under such circumstances is contrary to the presumption favoring judicial review as enunciated in *Bowen v. Michigan Academy of Family Physicians,* 106 S.Ct. 2133 (1986)?

LIST OF PARTIES AND RULE 28.1 LIST

The parties to the proceedings below were the petitioners Bethesda Hospital Association and The Deaconess Hospital of Cincinnati, Ohio, and the respondent Otis R. Bowen, M.D., Secretary of Health and Human Services.

The following Ohio hospitals were also plaintiffs-appellees in the proceedings below: Bethesda Hospitals, Inc. of Cincinnati; Brown County General Hospital; Clinton Memorial Hospital; Doctors Hospital, Inc.; Doctors Hospital of Nelsonville; Good Samaritan Medical Center; Grady Memorial Hospital; Guernsey Memorial Hospital; Kettering Medical Center; Lancaster-Fairfield Community Hospital; Madison County Hospital, Inc.; East Ohio Regional Hospital, Inc. d/b/a Martins Ferry Hospital; Medical Center Hospital; Memorial Hospital of Union County; The Mercy Hospital Corporation; Mercy Memorial Hospital of Urbana, Ohio, Inc.; Miami Valley Hospital; Ohio State University Hospitals; Our Lady of Mercy Hospital of Mariemont; Pike Health Services, Inc., d/b/a Pike Community Hospital; Riverside United Methodist Hospital; St. Ann's Hospital of Columbus, Inc.; St. John Medical Center; Sycamore Medical Center; and Shelby County Memorial Hospital Association, d/b/a Wilson Memorial Hospital. Because these hospitals are not affected by the jurisdictional issue presented for review, they are not named as parties herein.

The parent company of petitioner Bethesda Hospital Association is Care One Health Systems, Zanesville, Ohio.

The parent company of petitioner The Deaconess Hospital of Cincinnati, Ohio is The Deaconess Associates, Inc., Cincinnati, Ohio.

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v.

OTIS R. BOWEN, M.D., SECRETARY
OF HEALTH AND HUMAN SERVICES,
RESPONDENT.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

The petitioners Bethesda Hospital Association and The Deaconess Hospital of Cincinnati, Ohio respectfully pray that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Sixth Circuit, entered in the above proceeding on February 2, 1987.

OPINIONS BELOW

The opinion of the Court of Appeals for the Sixth Circuit is reported at 810 F.2d 558, and is reprinted in the appendix hereto, p. 1a, *infra*. The decision in ***Baptist Hospital East v. Secretary of HHS***, 802 F.2d 860 (6th Cir. 1986), by which the court below was bound, is reprinted in the appendix hereto, p. 10a, *infra*.

The memorandum decision of the United States District Court for the Southern District of Ohio (Spiegel, D.J.) is reported at 609 F.Supp. 1360, and is reprinted in the appendix hereto, p. 29a, *infra*.

The decision of the Provider Reimbursement Review Board is reprinted in the appendix hereto, p. 52a, *infra*.

JURISDICTION

The judgment of the Court of Appeals for the Sixth Circuit sought to be reviewed was issued and entered on February 2, 1987. The judgment was amended by an order entered February 25, 1987. App., p. 9a.

The due date for a petition for rehearing *en banc* was Monday, February 16, 1987, the Washington's Birthday holiday. Because February 16, 1987 was a legal holiday, and in the absence of a published local rule to the contrary, petitioners followed Rule 26(a) of the Federal Rules of Appellate Procedure (entitled "Computation of Time") and filed their petition for rehearing *en banc* on February 17, 1987, the day following Washington's Birthday. The petition was denied as untimely by one day by order dated March 16, 1987. Petitioners' motion for reconsideration of the March 16, 1987 order was denied by order filed April 8, 1987.

The jurisdiction of this Court to review the judgment of the Sixth Circuit is invoked under 28 U.S.C. § 1254(1).

STATUTE INVOLVED

42 U.S.C. § 1395oo. Provider Reimbursement Review Board.

> (a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g)(2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and

> which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—
>
> (1) such provider—
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or
>
> (ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,
>
> (B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or
>
> (C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,
>
> (2) the amount in controversy is $10,000 or more, and
>
> (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.
>
> * * *

(d) A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

* * *

(f)(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board or any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) and has filed a request for such a hearing,

such provider may file a request for a determination in writing by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5, United States Code, notwithstanding any other provisions in section 205. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

* * *

STATEMENT OF THE CASE

The petitioners are hospitals which are providers of inpatient hospital services to Medicare beneficiaries, pursuant to a "provider agreement" with the Secretary of

Health and Human Services ("Secretary"). At the end of each cost year, a provider must submit its cost report to its Medicare fiscal intermediary, which is generally a private insurance company that has a contract with the Secretary. The fiscal intermediary reviews and audits the cost report, and issues a Notice of Program Reimbursement (NPR) indicating the total amount of Medicare reimbursement due. In doing so, the intermediary is bound by the Medicare regulations and cannot allow costs in excess of those permitted under the regulations. If a provider is dissatisfied with the amount of reimbursement it receives, and the amount in controversy is $10,000 or more, it may file an appeal with the Provider Reimbursement Review Board ("Board").

The petitioners, together with 25 other Ohio hospital Medicare providers, filed a group appeal with the Board pursuant to 42 U.S.C. § 1395oo(a). The appeal challenged the validity of a Medicare regulation promulgated by the Secretary ("the 1979 Malpractice Rule", codified at 42 C.F.R. § 405.452(a)(1)(ii)(1984)) which drastically altered the method by which Medicare reimbursed providers for their malpractice insurance costs. With respect to all the other providers in the group appeal, the Board determined that it did not have authority to invalidate the regulation and granted expedited review pursuant to 42 U.S.C. § 1395oo(f)(1). This permitted the providers to file their challenge to the 1979 Malpractice Rule directly in district court.

However, with respect to the two petitioners, the Board determined that it did not have jurisdiction to hear their claims and dismissed their appeals. The petitioners had filed their cost reports in compliance with the 1979 Malpractice Rule, thus "self-disallowing" their claims for reimbursement of costs in excess of those allowed under the Rule. Neither the statute, the regulations nor any instructions require that a provider must violate a regulation and claim costs not permitted under that regulation in

order to preserve its appeal rights. Nevertheless, the Board held that it did not have jurisdiction to hear the "self-disallowances", because the petitioners had not claimed the costs in excess of those allowed under the 1979 Malpractice Rule on their cost reports, and therefore the fiscal intermediary had not disallowed the costs before issuing the NPR. App., p. 54a-57a.

The petitioners appealed the Board's denial of jurisdiction to the district court, pursuant to 42 U.S.C. § 1395oo(f)(1). The district court reversed the decision of the Board, finding that the plain language of § 1395oo(d), which authorizes the Board "to make any other revisions on matters covered by [the] cost report even though such matters were not considered by the intermediary in making such final determinations," gives the Board jurisdiction to hear self-disallowed claims, despite the fact the intermediary did not first deny such claims. App., p. 34a. The district court also held that the doctrine of exhaustion of administrative remedies does not support the Secretary's position that claims must first be presented to the intermediary, because the intermediary is bound by the Secretary's regulations and therefore cannot grant the relief the petitioners seek, i.e., invalidation of the 1979 Malpractice Rule. App., p. 39a-41a.

The court of appeals reversed the decision of the district court on the self-disallowance issue because it was bound by the previous decision of another panel of the Sixth Circuit in *Baptist Hospital East v. Secretary of HHS*, 802 F.2d 860 (6th Cir. 1986). App., p. 5a-6a. The panel in *Baptist Hospital East* found that where a provider complies with the Secretary's regulation in completing its cost report and effects a self-disallowance, it has disclaimed entitlement to reimbursement for costs in excess of those allowed under the regulations. App., p. 14a-16a. The *Baptist Hospital East* panel adopted the analysis of the Court of Appeals for the D.C. Circuit in *Athens Community Hospital, Inc. v. Schweiker*, 686 F.2d 989 (D.C. Cir. 1982)

(*Athens I*), *modified, Athens Community Hospital, Inc. v. Heckler,* 743 F.2d 1 (D.C. Cir. 1984) (*Athens II*). *Athens II* held that in order for the Board to have jurisdiction over a provider's appeal, a provider must present a claim for reimbursement or otherwise notify the intermediary of its dispute before the intermediary issues the NPR.

The court of appeals in the instant case rejected the petitioners' argument that this Court's decision in *Bowen v. Michigan Academy of Family Physicians,* 106 S.Ct. 2133 (1986) required that the statutory provision governing administrative and judicial review be construed in accordance with the presumption favoring judicial review. App., p. 6a. However, the court continued, "[w]ere we considering this [self-disallowance] issue as a matter of first impression, we may well have reached a different conclusion as to the advisability of requiring submission of statutory and/or constitutional challenges to a private insurance company as a condition precedent to further administrative as well as judicial review of the Secretary's regulations." App., p. 7a. As indicated in the jurisdiction section above, the court denied the petitioners' petition for rehearing *en banc.*

REASONS FOR GRANTING THE WRIT

I. A CONFLICT AMONG CIRCUIT COURTS OF APPEALS EXISTS AS TO THE PROPER INTERPRETATION OF THE MEDICARE JURISDICTIONAL STATUTE

A. *Primary Conflict*

Six courts of appeals have addressed the question whether, under § 1395oo, the Provider Reimbursement Review Board has jurisdiction to hear self-disallowed claims. To date, three different and distinct answers have been given to the question.

The Seventh Circuit, in *St. Mary of Nazareth Hospital Center v. Department of Health and Human Services,* 698 F.2d 1337 (7th Cir.), *cert. denied,* 464 U.S. 830 (1983),

held that the Board does have jurisdiction to hear self-disallowed claims. The court found that the language of § 1395oo(d) "vests broad authority" in the Board, and concluded that "since the statute allows the Board to consider matters outside of the cost reports," 698 F.2d at 1346, the Board can hear self-disallowances.

The District of Columbia Circuit, in *Athens II,* reached the contrary conclusion. The court found that the language of § 1395oo(d) creates two separate and independent grants of jurisdiction: 1) to review decisions made by the fiscal intermediary and 2) to make any other revisions. 743 F.2d at 4. However, the court went on to conclude that the second grant can only be exercised if necessary to accommodate any decisions made under the first grant of power, and does not give the Board independent authority to hear self-disallowances. 743 F.2d at 9. Central to the court's rationale was the notion that the intermediary's analysis and conclusions on the claims are essential to the Board's determination. 743 F.2d at 6-7. The Sixth Circuit in *Baptist Hospital East,* the Fourth Circuit in *Community Hospital of Roanoke Valley v. Health and Human Services,* 770 F.2d. 1257 (4th Cir. 1985), and the Eleventh Circuit in *North Broward Hospital District v. Bowen,* 808 F.2d 1405 (11th Cir. 1987), essentially adopted the *Athens* decision and held that the Board cannot hear self-disallowed claims.

Most recently, the First Circuit arrived at yet a third reading of the statutory language. In *St. Luke's Hospital v. Secretary of Health and Human Services,* 810 F.2d 325 (1st Cir. 1987), the court held that the language of § 1395oo(d) is clear and unambiguous in giving the Board the power to hear all "matters covered by [the] cost report", including self-disallowed claims. But the court went on to hold that this power is discretionary, and that it is up to the Board whether that power should be exercised in a given case.

The result of this three-way split among the circuits is that whether the Board will hear self-disallowed claims not raised with the intermediary as a contested claim prior to issuance of the NPR now depends on where the provider is located. If it is located in the Seventh Circuit, the answer is yes; if in the District of Columbia, the Fourth, Sixth or Eleventh Circuits, the answer is no; if in the First Circuit, the answer is maybe. District Courts outside these circuits have similarly split. *See, e.g., Metropolitan Medical Center and Extended Care Facility v. Heckler,* No. 3-84-411 (D. Minn. June 7, 1985) *reprinted in* Medicare and Medicaid Guide (CCH) ¶34,887 (no jurisdiction over self-disallowed costs); *Adams House Health Care v. Heckler,* 604 F. Supp. 110 (N.D. Cal. 1984), *appeal pending,* No. 85-1512 (9th Cir.) (jurisdiction exists over self-disallowed costs).

B. *Secondary Conflict*

A secondary conflict between the circuits involves whether the presumption favoring judicial review, recognized by this court in *Abbott Laboratories v. Gardner,* 387 U.S. 136, 141 (1967) and affirmed in the Medicare context in *Bowen v. Michigan Academy of Family Physicians,* 106 S. Ct. 2133 (1986), applies to the interpretation of statutory provisions setting forth the administrative and judicial review process. The Eleventh Circuit in *Memorial Hospital v. Heckler,* 706 F.2d 1130 (11th Cir. 1983), applied the presumption to interpret 42 U.S.C. § 1395oo(g), part of the statute governing administrative appeals to the Board. Subsection 1395oo(g) provides:

> The finding of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1395y of this title shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f) of this section.

The Eleventh Circuit held that where a provider seeks to challenge a regulation that defines which items are "personal comfort items" excluded from coverage under Section 1395y, administrative and judicial review is not precluded by subsection 1395oo(g). "Such a result would run contrary to the presumption favoring judicial review." 706 F.2d at 1133.

In contrast, the Sixth Circuit in the case below refused to apply the presumption favoring review to interpret the statutory provisions of § 1395oo governing appeals to the Board. The court held that the presumption favoring judicial review is applicable only where Congress has not provided a review mechanism, and that it does not apply to the interpretation of a statutory scheme for review. App., p. 5a-6a. This position is in conflict with that taken by the Eleventh Circuit.

The granting of this petition will achieve a uniform construction of the statutory language, assist the Secretary in the administration of the Medicare program, and ensure that all Medicare providers will understand what the statute requires.

II. THE DECISION BELOW CONFLICTS WITH A PREVIOUS DECISION OF THIS COURT.

In *Bowen v. Michigan Academy of Family Physicians,* 106 S.Ct. 2133 (1986), this Court emphatically affirmed the strong presumption favoring judicial review of agency actions in the Medicare context. Citing the legislative history of the Administrative Procedure Act, the Court acknowledged that only upon a clear and convincing showing of legislative intent to restrict access to review may those aggrieved by agency action be denied judicial review of their claims. 106 S.Ct. at 2136.

The effect of the interpretation given the Medicare statute by the court below is to deprive the petitioners of their right to an administrative and judicial review of their

challenge to the Secretary's regulation, despite the fact that they have met all the express requirements Congress specified in § 1395oo(a) for entitlement to such a hearing (*i.e.*, they filed cost reports, they are dissatisfied with the amounts of their NPRs, they appealed to the Board within 180 days, and the amounts in controversy exceed $10,000). Where Congress has not expressly stated that a dispute must first be raised with the intermediary as a prerequisite for entering the administrative appeals process, the reading of such a restrictive requirement into the statutory language is contrary to interpreting a remedial statute in accordance with the presumption favoring judicial review. Such a reading is inconsistent with *Michigan Academy*.

III. THIS ISSUE INVOLVES THE REQUISITE PUBLIC IMPORTANCE TO MEDICARE PROVIDERS THROUGHOUT THE NATION.

The question whether the Board has jurisdiction to hear self-disallowed claims affects all types of Medicare providers throughout the country that seek access to the administrative and judicial review process through the Provider Reimbursement Review Board. These providers include hospitals, skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities.

For hospitals, this issue continues to be important even with the advent of the Medicare prospective payment system (PPS) (effective October 1, 1983), under which hospitals receive a fixed amount per Medicare discharge, depending on the patient's diagnosis. First, those hospitals exempt from PPS (*e.g.*, children's hospitals, psychiatric hospitals) still receive cost reimbursement on the basis of their filed cost reports, and all their costs are subject to appeal to the Board. Second, those hospitals covered by PPS receive, for the first four years, interim rates based in part on a cost report filed in an earlier "base year," generally fiscal year 1982. Disputes concerning the base year cost

report (including the self-disallowance issue) are still in the administrative and judicial review process, and the result of those appeals will affect the hospitals' PPS rates. And third, these PPS hospitals continue to receive reimbursement for certain costs on a cost basis, which depends on the filing of cost reports in each PPS year. The self-disallowance issue can arise in any of these years.

In addition, all non-hospital providers are cost-reimbursed based on filed cost reports, and are entitled to appeal their cost reimbursement disputes to the Board. The self-disallowance issue can arise in any of these appeals.

Many of these providers in good faith complete their cost reports in accordance with the Secretary's regulations, even if they disagree with those regulations, unaware that such compliance may be deemed a waiver of their rights to challenge the validity of those regulations. Inasmuch as the Secretary's interpretation of the statute with respect to self-disallowances has never been promulgated as a regulation, the providers do not have notice of the Secretary's position.

Just as the Internal Revenue Service depends upon voluntary compliance with regulations by taxpayers, so does the Medicare program depend upon voluntary compliance with regulations by providers completing the complex Medicare cost report forms (over one-half inch thick when completed with accompanying worksheets). Yet the Secretary's interpretation requires providers to violate the regulations in order to preserve their appeal rights. This position undermines the goal of good-faith compliance by providers, and effective administration of the Medicare program.

CONCLUSION

For the foregoing reasons, this petition for a writ of certiorari should be granted.

Respectfully submitted,

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United States Court of Appeals For the Sixth Circuit

No. 86-3090

BETHESDA HOSPITAL, ET AL.,
Plaintiffs-Appellees,

v.

SECRETARY OF HEALTH AND HUMAN SERVICES,
Defendant-Appellant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF OHIO.

Decided and Filed February 2, 1987

Before: KEITH and GUY, Circuit Judges; and EDGAR, District Judge.*

GUY, Circuit Judge. Plaintiffs, a group of twenty-nine hospitals which are providers of services under the Medicare Act, challenged in the district court the promulgation of the 1979 Malpractice Rule by the Secretary of Health and Human Services. In addition, two of the hospitals contested a decision by the Provider Reimbursement Review Board (PRRB) that it lacked jurisdiction to review their claims because those claims were not properly raised in their cost reports filed with the fiscal intermediary. The following issues were presented to the district court:

> 1) Whether the Provider Reimbursement Review Board (PRRB) erred in concluding that it lacked jurisdiction over the claims of plaintiffs who self-

*Honorable R. Allan Edgar, United States District Court, for the Eastern District of Tennessee, sitting by designation.

disallowed malpractice insurance costs? 2) Is the challenged regulation invalid under the Administrative Procedure Act (APA) because of deficiencies in either the Notice of Proposed Rule Making or the Basis and Purpose statement accompanying the regulation in final form? 3) Is the challenged regulation violative of the APA as arbitrary and capricious, an abuse of discretion or otherwise not in accordance with law? 4) Is the challenged regulation invalid because it is inconsistent with the Medicare Act?

609 F. Supp. 1360, 1363 (S.D. Ohio 1985).

After review of the administrative record and filings by counsel, the district court concluded that:

> 1) The PRRB erred in concluding that it lacked jurisdiction over the claims of the health care providers who "self-disallowed" the malpractice insurance costs; 2) the challenged regulation is violative of the APA in two respects: a) the regulation in final form was not accompanied by an adequate statement of basis and purpose; and b) the issuance of the regulation, based upon the data on which the Secretary relied, was arbitrary and capricious. We do not rule on the issue of whether the challenged regulation is invalid because of alleged inconsistency with the Medicare Act.

Id.

Based on these conclusions, the court granted the plaintiff-hospitals' (the hospitals) motion for summary judgment and ordered further briefing on the issue of the appropriate relief. On November 25, 1985, the court issued an order remanding the case to the Secretary for the purpose of granting judgment to the hospitals in the amount of $2,965,767.00 plus interest. The court specifically declined to remand the case to the Secretary for application of any retroactive rulemaking which might

result from the Notice of Proposed Rulemaking published by the Secretary on June 17, 1985. 50 Fed. Reg. 25,178. The Secretary timely appealed this order of remand and argues the following issues on appeal:

> 1. Whether, in light of the promulgation of the 1986 Malpractice Rule on April 1, 1986 (51 Fed. Reg. 11,142, appearing at 42 C.F.R. § 413.56),[1] this case is now moot and the district court's decision should thus be vacated and the complaint dismissed.
>
> 2. Assuming *arguendo* that the case is not technically moot, whether the appropriate relief is to remand this case to the district court with instructions to remand to the Secretary for application of 42 C.F.R. § 413.56 to the cost years in plaintiffs' complaint.
>
> 3. Whether the district court erred in concluding that the Provider Reimbursement Review Board (PRRB) should have exercised jurisdiction over the claims of plaintiffs Bethesda Hospital and Deaconess Hospital.

For the reason below, the decision of the district court is affirmed in part and reversed in part.

I.

With respect to the first two issues on appeal, the Secretary argues that the 1986 Rule, promulgated subsequent to the district court decision in this case, automatically supercedes the invalidated 1979 Rule since, by its terms, it applies to cost reporting periods beginning July 1, 1979. Therefore he contends that, since the 1986 Rule has not yet been applied to the hospitals' cost reports

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[1] The Secretary has advised the court that the interim final rule, originally to be codified at 42 C.F.R. § 405.457, has been redesignated as 42 C.F.R. § 413.56. *See* 51 Fed. Reg. 34,790 and 34,808-09 (September 30, 1986).

for the contested years (1980 and 1981), there is no "final decision" of the PRRB, a prerequisite to federal court jurisdiction. He argues that, since the 1986 Rule automatically supplants the invalid 1979 Rule and governs the cost years in question, there is no longer a "live controversy" between the parties or, in the alternative, that the case must be remanded to the PRRB for issuance of a final decision pursuant to the *1986 Rule* before the court can properly entertain jurisdiction over the hospitals' claims.

In so arguing, the Secretary ignores Supreme Court authority stating that a dispute involving a monetary judgment constitutes a concrete interest in the outcome of the litigation and precludes a finding of mootness based on subsequent events. *Ellis Brotherhood of Railway, Airline and Steamship Clerks,* 466 U.S. 435 (1984); *New York City Transit Authority v. Beazer,* 440 U.S. 568, 580-81 (1979) ("the case is not moot since their claims arose even before the Act itself was passed, and they have been awarded monetary relief"). Further, the Secretary's argument presumes that it is the agency's sole province to determine the issue of retroactivity. This precise issue arose and has been decided by this court in our opinion in *Mason Hospitals v. Bowen,* No. 86-1011, where we held that the Secretary is prohibited from applying the 1986 Rule retroactively to 1979. Since our decision in that case is dispositive of the first two issues on appeal here, we hereby adopt the rationale expressed in *Mason* with reference to the twenty-seven hospitals in this case whose right to contest the retroactive effect of the 1986 Rule is undisputed.

II.

The only issue remaining is the jurisdictional one involving Bethesda and Deaconess Hospitals. The factual background relative to this issue follows.

Twenty-seven of the plaintiff-hospitals notified the fiscal intermediary at the time they filed their cost reports for 1980 and 1981 that they disputed the validity of the 1979 Malpractice Rule and its application to their claims for malpractice premium reimbursement. However, both Bethesda and Deaconess Hospitals complied with the 1979 Rule by completing and attaching Schedule D-8 to their cost reports, "Apportionment of Malpractice Insurance Costs." Schedule D-8 required hospitals to list their total malpractice insurance costs and then apply the methodology of the 1979 malpractice regulation in determining allowable Medicare costs.

The hospitals' cost reports thus included a claim for reimbursement for malpractice insurance costs, but completion of Schedule D-8 thus effectuated a "self-disallowance" of such malpractice insurance costs in excess of those allowed under the 1979 Rule. Because these hospitals complied with the Secretary's regulation and cost report instructions, there was no need for the fiscal intermediary reviewing their cost reports to make an audit adjustment with respect to the malpractice insurance issue before issuing a Notice of Program Reimbursement.

These hospitals timely filed requests for a hearing with the PRRB, seeking reimbursement for malpractice insurance costs under the pre-1979 utilization methodology. The PRRB determined that it was without jurisdiction over the claims of Bethesda and Deaconess Hospitals because they had failed to adequately present a "claim" for their premium reimbursements sufficient to notify the intermediary of a "dispute" as to this cost item.

In *Bapist Hospital East v. Secretary of HHS,* 802 F.2d 860 (6th Cir. 1986), this precise issue was addressed by another panel of this court. Following the rationale of the District of Columbia Circuit in *Athens Community Hospital, Inc. v. Schweiker,* 743 F.2d 1 (D.C. Cir. 1984) (Athens II), we held that the PRRB had properly refused

to exercise jurisdiction over those claims by providers who had self-disallowed reimbursement and had failed to challenge the Secretary's regulations before the fiscal intermediary. *See also University of Cincinnati v. Heckler*, No. 85-3651 (6th Cir. 1986) (reaching the same conclusion). At oral argument before the panel, counsel for the hospitals raised the argument that the Supreme Court's recent decision in *Bowen v. Michigan Academy of Family Physicians*, 106 S. Ct. 2133 (1986), wherein the Court emphatically upheld the presumption of reviewability of agency determinations, requires us to review our holding in *Baptist Hospital*.

Michigan Academy dealt with a challenge to the validity of a regulation promulgated under Part B of the Medicare Program, which provides reimbursement to physicians and other individuals who render services to covered participants. The question presented in that case was whether Congress intended to entirely bar judicial review of amount determinations under Part B by enactment of 42 U.S.C. §§ 1395ff, 1395ii, and 1395u. Despite the government's contention to the contrary, the Court held that these statutes foreclosed judicial review of only particular, individualized *amount* determinations but not challenges to the *method* by which such determinations were made.[2]

We find *Michigan Academy* inapposite to the issue presented in the case at bar. That case dealt only with the right to judicial review in the absence of meaningful administrative review procedures and in view of 42 U.S.C.

[2] "In light of Congress' express provison for carrier review of millions of what it characterized as 'trivial' claims, it is implausible to think it intended that there be *no* forum to adjudicate statutory and constitutional challenges to regulations promulgated by the Secretary." *Michigan Academy*, 106 S. Ct. at 2140 (emphasis in original).

§ 405(h),[3] which has been construed to confine judicial review to those cases which have exhausted available administrative remedies. Title 42, U.S.C. § 1395oo clearly establishes a scheme of administrative review of providers' disputes via the PRRB, and we deal here with statutory interpretation of that section and the proper scope of the PRRB's function and not with a situation in which no scheme of administrative review is provided and the Secretary is attempting to foreclose judicial review as well. Since provider appeals proceed under an established system of administrative review, our holding in *Baptist Hosptial* was essentially one which defined the *steps* in that process to include submission of a "claim" before the fiscal intermediary as a prerequisite to PRRB and judicial review, in essence an exhaustion requirement.

Were we considering this issue as a mater of first impression, we may well have reached a different conclusion as to the advisability of requiring submission of statutory and/or constitutional challenges to a private insurance company as a condition precedent to further administrative as well as judicial review of the Secretary's regulations. However, "[a] panel of this Court cannot overrule the decision of another panel. The prior decision remains controlling authority unless an inconsistent decision of the United States Supreme Court requires modification of the decision or this Court sitting *en banc* overrules the prior decision." *Salmi v. Secretary of Health*

[3] (h) Finality of Secretary's decision

The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

42 U.S.C. § 405(h).

and Human Services, 774 F.2d 685, 689 (6th Cir. 1985) (citation omitted). Since we do not find the Supreme Court's holding in *Michigan Academy* to require modification of *Baptist Hospital*, we are constrained to follow that decision.

Therefore, the decision of the district court is AFFIRMED with respect to its grant of judgment in favor of the twenty-seven named hospitals in the amount of $2,965,767.00 plus statutory interest. The court's decision with respect to Bethesda and Deaconess Hospitals is REVERSED and REMANDED for dismissal in accordance with this opinion.

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 86-3090

BETHESDA HOSPITAL, ET AL.,
Plaintiffs-Appellees,

v.

SECRETARY OF HEALTH AND HUMAN SERVICES,
Defendant-Appellant.

Filed FEB 25, 1987

ORDER

Before: KEITH and GUY, Circuit Judges; and EDGAR, District Judge.*

The Secretary has filed a motion to correct judgment. The panel agrees and grants the Secretary's motion. The final paragraph of the opinion filed on February 2, 1987, is hereby amended to read as follows:

> Therefore, the decision of the district court is AFFIRMED with respect to its grant of judgment in favor of the twenty-seven named hospitals in the amount calculated by the Secretary pursuant to the distrcit court's amended order of February 20, 1986. The court's decision with respect to Bethesda and Deaconess Hospitals is REVERSED and REMANDED for dismissal in accordance with this opinion.

IT IS SO ORDERED.

Entered by Order of the Court

/s/ JOHN P. HEHMAN, CLERK
John P. Hehman
Clerk

*Honorable R. Allan Edgar, United States District Court, for the Eastern District of Tennessee, sitting by designation.

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 85-5473

BAPTIST HOSPITAL EAST, ET AL.,

v.

SECRETARY OF HEALTH AND HUMAN SERVICES

October 6, 1986

Before: ENGEL and MILBURN, Circuit Judges, and CONTIE,* Senior Circuit Judge.

ENGEL, Circuit Judge. Appellants, five non-profit hospitals, are all providers of health care services under the Medicare program who, during the relevant period, provided some free health care to non-Medicare patients. These services were accounted for by the hospitals as either bad debts, charity or courtesy allowances.[1] The

* Judge Leroy J. Contie took senior status on July 1, 1986.

[1] The Secretary has defined bad debts, charity and courtesy allowances as follows:

(b) Definitions—(1) Bad debts. Bad debts are amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the rendering of services, and are collectible in money in the relatively near future.

(a) Charity allowances. Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient. Cost of free care (uncompensated services) furnished under a Hill-Burton obligation are considered as charity allowances.

(3) Courtesy allowances. Courtesy allowances indicate a reduction in charges in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of

hosptials now seek reimbursement from the Medicare program for a portion of these services. They appeal a decision of the United States District Court for the Western District of Kentucky upholding 42 C.F.R. § 405.420 under which the Secretary of Health and Human Services denied their claims for reimbursement. We agree with Chief Judge Charles M. Allen that a provider's self-disallowance is not a matter covered by its cost report and does not preserve the jurisdiction of the Provider Reimbursement Review Board with respect to the self-disallowance, that Reg. Sec. 405.420 does not conflict with the reasonable cost provisions of the Medicare Act, 42 U.S.C. § 1395x(v)(1)(A), and that Reg. Sec. 405.420 does not violate the due process clause of the Fifth Amendment.

I.

To recover costs incurred in providing health care services to Medicare recipients, a provider must file a cost report with the Department of Health and Human Services, usually through a private insurance company acting as an agent for the Secretary and denominated a "fiscal intermediary." The appellants, in filing their cost reports with their fiscal intermediary, claimed compensation from the Medicare program for a portion of their bad debts, charity and courtesy allowances, while one appellant, William Booth Memorial Hospital, self-disallowed reimbursement for its free services on its cost report for fiscal 1981.[2] The fiscal intermediary rejected the claims for

the provider, for services received from the provider. Employee fringe benefits, such as hospitalization and personnel health programs, are not considered to be courtesy allowances. 42 C.F.R. § 405.420(b).

[2] To self-disallow a cost, the provider lists that cost on Worksheet A-8 (adjustments to expenses) of its cost report, "but does not request reimbursement for that item because it believes that reimbursement is barred by the Medicare regulations." *Athens Community Hosp., Inc. v. Schweiker,* 743 F. 2d 1, 5 (D.C. Cir. 1984).

reimbursement for bad debts, charity and courtesy allowances in accordance with 42 C.F.R. § 405.420(b). The providers appealed as part of a group appeal from these denials to the Provider Reimbursement Review Board pursuant to 42 U.S.C. § 1395*oo*, challenging 42 C.F.R. § 405.420 and seeking expedited judicial review. Booth Memorial, along with other providers who had not claimed recovery for bad debts, charity and courtesy allowances sought to join the appeal to the Board.

The Board dismissed the appeals of several hospitals on the ground that it lacked jurisdiction to hear a claim not initially raised with the fiscal intermediary. It granted the remaining hospitals' request for expedited judicial review under 42 U.S.C. § 1395*oo*(f)(1) since only a controlling question of law, which the Board was not empowered to decide, remained at issue. The provider then filed suit in the district court.

The district court granted summary judgment against those hospitals, including Booth, which did not expressly claim reimbursement for their free services but made self-disallowing adjustments. It held that those hospitals had failed to satisfy the jurisdictional prerequisites for appeal to the Board.

> [A] mere self-disallowance, which is no more than setting out a figure on a cost report without claiming it, is insufficient to preserve the jurisdiction of the Board to consider that item for reimbursement purposes. . . . A provider simply cannot request reimbursement from the Board for an item which it did not even claim from its fiscal intermediary before receiving its NPR.

The court further upheld the challenged regulations as "entirely consistent" with the Medicare Act and as not in violation of the Fifth Amendment due process clause.

On appeal, the hospitals argue that bad debts and charity allowances are necessary costs of hospital operation, a portion of which are indirectly attributable to the Medicare program and are accordingly recoverable as reasonable costs under 42 U.S.C. § 1395x(v)(1)(A).[3] They contend that 42 C.F.R. § 405.420, which precludes recovery for general bad debts and charity allowances, is inconsistent with the reasonable cost provisions of the Act. They further contend that 42 C.F.R. § 405.420, to the extent it does not compensate the hospitals for costs of operation attributable to the Medicare program, effects a taking without compensation in violation of the due process clause of the Fifth Amendment. William Booth Memorial Hospital also contends that its self-disallowance of reimbursement for free services provided sufficient notice to preserve its right to appeal to the Board under section 1395*oo*.

II.

The review process for the claims of Medicare providers is established through 42 U.S.C. § 1395*oo*, in which Congress created the Provider Reimbursement Review Board.[4]

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[3] At oral argument, appellants relinquished their claim for recovery on courtesy allowances.

[4] Section 1395*oo* states:

> (a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if –
>
> (1) such provider –
>
> (A)(1) is dissatisfied with a final determination of the organization serving as its fiscal intermediary . . . as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report . . .
>
> (d) . . . The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with

Booth contends that the Board has jurisdiction under Sec. 1395*oo* to review the cost items that Booth self-disallowed since under that section the Board make "may any other revisions on matters covered by such cost report . . . even though such matters were not considered by the intermediary in making such final determination." Booth argues that the items it self-disallowed may be reviewed by the Board as items covered in the cost report and not considered by the intermediary.

There is a division of authority on this issue both within the circuits and within the district courts of this circuit. This circuit has held, though, that Sec. 1395*oo* "requires that a provider include disputed issues within the initial cost report and preserves the right of review if the intermediary ignores the claim, or instructs the provider to delete the claim. . . . The provider is not entitled to compel the Board to review *new* claims." *Saline Community Hosp. Ass'n v. Secretary of H. H. S.*, 744 F.2d 517, 519 (6th Cir. 1984) (per curiam) (original emphasis). By self-disallowing its bad debts, charity and courtesy allowances Booth did not claim them; on the contrary, through self-disallowance without an accompanying challenge, Booth expressly disclaimed entitlement to reimbursement. We do not believe that a mere self-disallowance even when made solely to conform to regulations with which a provider disagrees raises a claim within the meaning of *Saline* sufficient to preserve the issue for review by the Provider Reimbursement Review Board.

In *Athens Community Hosp., Inc. v. Schwicker*, 743 F.2d 1 (D.C. Cir. 1984) (*Athens II*), the D.C. Circuit held that "the PRRB has jurisdiction over costs that are specifically claimed—meaning that the provider requested

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respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination. 42 U.S.C. § 1395*oo*(a)(1)(A)(1) and (d).

reimbursement in a timely manner—as well as those cost issues raised by a provider prior to the intermediary's issuance of the NPR." Id. at 5-6. The court rejected the interpretation of section 1395*oo* stated by the Seventh Circuit in *St. Mary of Nazareth Hosp. Center v. Department of H.H.S.*, 698 F.2d 1337 (7th Cir.), *cert. denied*, 464 U.S. 830 (1983), which granted jurisdiction to the Board over all matters whether or not disclosed in the cost report.[5] It held that the interpretation would render meaningless the statute's provision for revision by the Board of "matters covered by [a] cost report." *Athens II*, 743 F.2d at 6. The court further held that section 1395*oo* does not grant jurisdiction to the Board over items self-disallowed on the cost report. It concluded that any other interpretation would put "an irrational gloss on the statute." Id.

> It simply is not plausible to contend that Congress has created a scheme where the provider can claim dissatisfaction and have recourse to an appeal procedure because the intermediary failed to read the provider's mind and anticipate all those things the provider would like to be reimbursed for, even though it did not request them. Id.

Moreover, it concluded that such an interpretation would place an overwhelming burden of identifying reimbursable costs on the intermediary.

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[5] The Seventh Circuit in *St. Mary* stated that "the statute allows the Board to consider matters outside of the cost reports. . . ." 698 F.2d at 1346. This statement, as the D.C. Circuit noted, ignores the second part of the jurisdictional grant in section 1395*oo*. The holding of *St. Mary*, however, is not necessarily so broad. See *St. Luke's Hosp. v. Secretary of H. H. S.*, 632 F. Supp. 1387 (D. Mass. 1986). In *St. Mary*, the provider had self-disallowed the costs for which it was seeking Board review. Accordingly, *St. Mary* could be limited to the proposition that section 1395*oo* extends Board jurisdiction to costs which were self-disallowed as "matters covered by [the] cost report. . . ." As noted below, we agree with the D. C. Circuit that even this interpretation of section 1395*oo* is unwarranted.

> Thus a provider could list every conceivable cost on its cost report, without claiming reimbursement, and hope that the intermediary will reimburse it for the reported but unclaimed costs, secure that it nevertheless will have until 180 days following the NPR to concoct some reasons to urge upon the PRRB for reimbursement of the unclaimed costs. Id.

It noted that permitting de novo claims at the Board level would generate baseless appeals and that such an interpretation runs counter to the process of progressive narrowing of issues reflected in the procedures for reopening a cost report.

We note that in the instant case Booth self-disallowed its bad debts and charity allowances simply because it was compelled to do so under the regulations. We further recognize that the intermediary has no authority to alter the Secretary's regulations governing reimbursement but must faithfully apply them as they stand. This is not a case, then, where extending jurisdiction over costs not claimed in the report would saddle the intermediary with an additional obligation. If the Board's jurisdiction were extended to this type of case, the Board would not have to search out unclaimed costs that were disallowed under close regulatory directives since, even if it had considered these costs, it could not have awarded reimbursement for them. Moreover, we recognize that in this situation, requiring a provider to claim reimbursement does not serve the purpose generally served by exhaustion requirements. Since the intermediary cannot review the Secretary's regulations, it cannot offer the assistance of its analysis. See *Bethesda Hosp. v. Heckler,* 609 F. Supp. 1360, 1368 (S.D. Ohio 1985). Booth's interpretation of Sec. 1395*oo* does not in these circumstances "deprive [the PRRB] of the intermediary's analysis and conclusions and make the PRRB the tribunal of original jurisdiction, eliminating a tier of review, and possibly substantially slowing the

reimbursement process for other providers." *Athens Community Hosp. Inc. v. Schweiker,* 686 F.2d 989, 997 (D.C. Cir. 1982) (*Athens I*), *modified,* 743 F.2d 1 (1984).

Nonetheless, even if we see little reason for requiring a provider to raise a claim before a body that cannot address it, we are not free to design an agency process for review of intermediary decisions on cost reports, but are bound to apply Congress' intent where it can be determined and to defer to the Secretary's interpretation where it is reasonable. We agree with the D.C. Circuit that the interpretation stated by the Seventh Circuit renders the second part of the jurisdictional grant meaningless. Moreover, we agree that the interpretation which grants jurisdiction over costs for which the provider did not seek reimbursement places an irrational gloss on the statute. The interpretation adopted in *Athens II* and applied by the Board in this and other cases, in contrast, does no damage to the language of the statute and serves a beneficial procedural purpose. Under *Athens II* and the Board's interpretation, a provider is required to present a coherent claim for reimbursement at the time it files its cost report. It may not present claims to it intermediary, await the intermediary's decision, and then decide based upon its success before the intermediary whether to raise additional claims before the Board. "This procedure would . . . render virtually meaningless the time limits for the filing of cost reports established by Medicare regulations." *Athens II,* 743 F.2d at 7.[6] Finally, we note

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[6] In *Bethesda,* Judge Spiegel expressed concern that the interpretation of section 1395*oo* adopted in *Athens II* would preclude review by the Board and the courts of errors made by an intermediary in favor of a provider. We do not fear such a result. Section 1395*oo*, permits the Board to make "revisions adverse to the provider of services." This provision clearly allows the Board to reach issues not raised by the provider in its appeal. It is not inconsistent with the requirement that a provider claim a cost with its intermediary before seeking reimbursement for that cost at the Board. It simply allows the Board to make any revisions to the NPR mandated by its decision on the issue

that the interpretation adopted here does not place the provider at any disadvantage for exercising its right to challenge in good faith regulations which it believes are in conflict with their statutory underpinnings.[7] The *Provider Reimbursement Manual* states that there will be no referral to the U.S. Attorney for criminal and/or civil prosecution of a provider where the provider has claimed reimbursement for disallowed costs so long as "[t]he provider clearly indicates this item(s) is being included in the cost report only to establish the basis for an appeal and each disputed item and amount is specifically identified." *P. R. Manual* § 2425.1. [now *Manual* Sec. 2905.2, ¶ 7665] Moreover, under the reasoning of *Athens II*, a provider is able to appeal to the Board when it has self-disallowed a cost but also timely indicated its disagreement with and challenge to the regulations or rulings compelling the self-disallowance.

In the present case, Booth did not claim reimbursement for its bad debts and charity or courtesy allowances in its initial cost report but instead self-disallowed reimbursement for those matters and did not challenge the regulations under which it self-disallowed. Accordingly, Booth's bad debts and charity and courtesy allowances are not claims and the Board lacked jurisdiction to consider them.

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appealed, regardless of whether that revision was raised as an issue by the provider. Thus, if the provider appeals the denial of one claim and the Board's reversal of the intermediary's denial would necessitate a revision of other claims, the Board is empowered to make those revisions.

[7] Several courts have expressed concern that requiring a provider to claim a cost as a prerequisite to Board and judicial review places the provider in an untenable position when the cost has previously been denied by its intermediary or the Secretary. See *St. Luke's Hosp. v. Secretary of H. H. S.*, 632 F. Supp. 1387 (D. Mass. 1986); *Community Hosp. of Roanoke Valley v. Heckler*, 588 F. Supp. 674, 678 (D. Va. 1984), *aff'd in part and rev'd in part*, 770 F. 2d 1257 (4th Cir. 1985); *Adams House Health Care v. Heckler*, 604 F. Supp. 110, 115 (N. D. Cal. 1984); *Our Lady of Lourdes Memorial Hosp. v. Schweiker*, No. 80-CV-226 slip op. (N. D. N. Y. July 26, 1982).

III.

Those hospitals that did claim reimbursement on their cost reports for their charity allowances and bad debts contend that 42 C.F.R. § 405.420 is inconsistent with the reasonable cost provisions of the Medicare Act.

The Medicare Act allows for the payment of, at most, the "reasonable cost" of health care services to providers who charge the public more than a nominal sum for such services. 42 U.S.C. § 1395f(b).[8] Congress defined "reasonable cost" as the amount actually incurred and necessary to the efficient delivery of needed health services. 42 U.S.C. § 1395x(v)(1)(A).[9] Congress left the imple-

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[8] At the time the hospitals filed their cost reports, sec. 1395f(b) provided:

> The amount paid to any provider of services (other than a hospice program providing hospice care) with respect to services for which payment may be made under this part shall, subject to the provisions of sections 1395e and 1395ww of this title, be—
>
> (1) except as provided in paragraph (3), the lesser of (A) the reasonable cost of such services, as determined under section 1395x(v) of this title and as further limited by section 1395rr(b)(2)(B) of this title, or (B) the customary charges with respect to such services. . . .

[9] 42 U.S.C. § 1395x(v)(1)(A) provides:

> (1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services . . . Such regulations [establishing the method to determine costs] shall (i) take into account both direct and indirect costs of providers of services . . . in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

mentation of this definition to the Secretary, but required that any regulations account for indirect as well as direct costs and further provided:

> [T]he necessary costs of efficiently delivering covered services to individuals covered by the insurance programs . . . will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs. . . 42 U.S.C. § 1395x(v)(1)(A)(i).[10]

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[10] Pursuant to this authority, the Secretary promulgated the following regulations:

> (a) *Principle.* Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost; however, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the program. . . .
>
> (d) *Requirements for title XVIII.* Under Title XVIII of the Act, costs of covered services furnished beneficiaries are not to be borne by individuals not covered by the health insurance program, and conversely, costs of services provided for other than beneficiaries are not to be borne by the health insurance program. Uncollected revenue related to services rendered to beneficiaries of the program generally means the provider has not recovered the cost of services covered by that revenue. The failure of beneficiaries to pay the deductible and coinsurance amounts can result in the related costs of covered services being borne by other than beneficiaries of title XVIII. To assure that such covered service costs are not borne by others, the costs attributable to the deductible and coinsurance amounts which remain unpaid are added to the title XVIII share of allowable costs. Bad debts arising from other sources are not allowable costs.
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> (e) *Criteria for allowable bad debt.* A bad debt must meet the following criteria to be allowable:
>
> (1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
>
> (2) The provider must be able to establish that reasonable collection efforts were made.
>
> (3) The debt was actually uncollectable when claimed as worthless.

The hospitals argue that "the legislative history is clear" that through the Medicare Act Congress "intended to pay actual costs to meet the financial requirements of efficiently operating and maintaining a hospital." They maintain that their bad debts and charity allowances are actual indirect costs which must be recovered to operate a hospital efficiently and therefore are necessary to effectively deliver needed health care services to individuals covered by the Medicare program. Consequently, they contend that bad debts and charity allowances fall within the definition of reasonable costs and that the regulations disallowing partial reimbursement for bad debts and charity are inconsistent with the Act. The Secretary, though, contends that these are not actual costs attributable to health care services provided to recipients of Medicare assistance and that the system of allocating costs under the existing regulations is not inconsistent with the Act.

When construing the Medicare Act, we must defer to the interpretation made by the Department of Health and Human Services as the agency charged with administration of the statute. See *Schweiker v. Hogan,* 457 U.S. 569, 588 (1982). The Secretary's interpretation must be analyzed in light of the statute's language, purpose and history, and should be upheld if it is reasonable, consistent with the statutory mandate and does not frustrate the policy that Congress sought to implement. *Southeastern Community College v. Davis,* 442 U.S. 397 (1979); *Connecticut Dept. of Income Maintenance v. Heckler,* 105 S. Ct. 2210, 2215 n. 21 (1985); *State of Ohio v. United States Dept of Health & Human Serv.,* 761 F.2d 1187, 1193 (6th Cir. 1985).

> (4) Sound business judgment established that there was no likelihood of recovery at any time in the future. . . .
>
> (g) *Charity allowances.* Charity allowances have no relationship to beneficiaries of the health insurance program and are not allowable costs. . . . 42 C.F.R. § 405.420.

The Seventh Circuit has held that the regulations challenged here are "in complete harmony with both the letter and the spirit of the statue. . . ." *St. Francis Hosp. Center v. Heckler,* 714 F.2d 872, 887 (7th Cir. 1983), *cert. denied,* 465 U.S. 1022 (1984). We agree. The Secretary's regulations permit hospitals to recover from the Medicare program the uncollectible receipts, whether accounted for as bad debts or charity allowances, that are due from Medicare patients themselves. The Secretary has thus ensured the health care providers will not operate at a loss on the services provided to Medicare insureds. Congress did not require the Medicare program to reimburse health care providers for the proportion of their bad debts and charity allowances equal to the proportion of their patients who are Medicare insureds. That this might also be a reasonable scheme under the Act is not relevant. We need only consider whether the Secretary's regulations are reasonable in light of the Act; they need not be the only reasonable application of the Act. *Connecticut Dept. of Income Maintenance,* 105 S.Ct. at 2215. The characterization of bad debts and charity allowances as reductions in revenue rather than operating costs, and the Secretary's decision to pay the bad debts and free care costs of Medicare patients and to deny reimbursement for bad debts and free care of non-Medicare patients, is not an unreasonable scheme for allocating health care costs and does not conflict with the meaning of Sec. 1395x(v)(1)(A) as revealed by its language, purpose and history.

The Senate report provides an example of what Congress contemplated would be a reimbursable cost as well as what would not be reimbursable under the Medicare Act. It states that costs incurred by a health care provider pursuant to educational activities would be recoverable under the Medicare program because, "they enhance the quality of care in an institution," and are not borne by the community in any other way. S. Rep. No. 404, 89th Cong., 1st

Sess., *reprinted in* 1965 U.S. Code Cong., & Ad. News 1943, 1977. However, the report states that recovery would be denied for identifiable expenses for medical research:

> Identifiable expenses for medical research, on the other hand, over and above the costs closely related to normal patient care, would not be met from the trust fund. Available research funds are generally ample to support important basic medical research. Id.

Unquestionably, charity allowances and lost revenues attributable to bad debts reduce a hospital's gross receipts.[11] This will be true whether the particular loss was occasioned by motives of charity, by poor fiscal management, or simply by normal risk-taking inherent in every undertaking. It is also true that uncollected accounts receivable, like increased expenses incurred in providing patient care, can be made up by raising charges for normal patient care. In our judgment these factors do not, however, entitle them to be treated as costs "closely related to normal patient care" as Congress meant that term to be understood in the Medicare Act.

The hosptials, in essence, do not complain that the Secretary has refused reimbursement for a portion of the costs that a hospital must incur to properly service all its patients. Rather, they contend that they are not receiving from charges to patients a return sufficient to continue

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[11] The Secretary's regulations do not ignore the need of proprietary hospitals to recover economic costs through a sufficient return on equity. They provide for the payment of a reasonable return on equity either as part of or in addition to reimbursement of reasonable costs. See 42 U.S.C. § 1395x(v)(1)(B), 42 C.F.R. § 405.429. Congress, however, did not intend nonproprietary facilities, such as appellants, to collect a return on equity capital as part of the "reasonable costs" of providing services. *St. Francis,* 714 F. 2d at 875.

operation of the hospital or engage in improvements. While Congress intended to provide for reimbursement of normal patient care costs, contrary to the hospital's contention, neither the legislative history nor subsequent cases reveals a Congressional intent to guarantee a return from overall hospital functions adequate to ensure sustained hospital operation. In enacting the Medicare program, Congress did not primarily seek to ensure the financial viability of individual health care institutions, but sought to ensure adequate health care for a specific group of people.

> We do not find in the statute authorizing Medicare and Medicaid any legislative intention to provide financial assistance to providers of care for their own benefit. Rather, the statute is designed to aid the patients and clients of such facilities. *Green v. Cashman*, 605 F.2d 945, 946 (6th Cir. 1979).

It is evident that when Congress enacted the Medicare program it considered the problems that bad debts and free care pose for health care institutions. It recognized that the program would in reality provide a major source of relief from the risk of economic loss through payments on behalf of the elderly; just as plainly it did not intend to assume the risk incurred in serving those not covered by the program.

> In some cases, the charges hospital patients pay include a share of the cost of rendering services to free and part-pay patients as well as a share of uncollectible bills. The committee has given careful consideration to the question of the effect that the proposed program would have on charges to other paying patients. The insurance system will reduce the losses of hospital income from bad debts or for care of free or part-pay aged patients which might otherwise be included in charges to other paying patients by paying the full cost, execpt for the deductible and coinsurance, for substantially all patients over 65. Under the public assistance programs now existing and even more as they would exist under the provisions of this bill, the Federal Government will make a very substantial contribution toward the medical care of the needy of all ages. Under the bill more of the needy could be aided under the Federal-State assistance programs. Further, the proposed amendments would require under the medical assistance and maternal and child health and crippled children programs of the Social Security Act, the payment of the reasonable costs of covered hospital services. This will assist hospitals in reducing income deficits arising out of providing hospital care to persons unable to pay for care. These provisions, taken in combination with the hospital insurance system under part A of title XVIII, will appreciably reduce the need of hospitals to charge their paying and prepaying patients more than the cost of their services in order to compensate for care rendered to other patients without charge or at less than cost. The bill will thus make a contribution toward rationalizing the distribution of hospital costs and relieving voluntary insurance and prepayment systems, as well as those patients who pay for services at the time when they are rendered, of some part of the burden they now bear for indigent and charity patients. S. Rep. No. 404, 1965 U.S. Code Cong. & Ad. News at 1977-78.

Congress has enacted other programs to help ensure an ample number of health care institutions, see, e.g., 42 U.S.C. § 261a; *Newsom v. Vanderbilt University*, 653 F.2d 1100, 1104-05 (6th Cir. 1981), and we have held that the Medicare Act does not also serve that purpose. In the face of arguments similar to those raised here, courts have repeatedly held that free care costs incurred by the health care providers in satisfaction of obligations they assumed

in order to receive federal funding under the Hill-Burton Act are not recoverable as reasonable costs under the Medicare program because the Medicare Act was not designed to finance improvements in health care facilities.

> [T]hese two Acts as established are two separate and distinct federal programs, each designed to accomplish a distinctly different purpose. The Hill-Burton Act was designed to promote the construction and modernization of hospitals. . . . The Medicare Act, on the other hand, was adopted only to provide medical care for the disabled and the aged who qualify as Medicare beneficiaries. *St. Mary,* 698 F.2d at 1343. See also *Harper-Grace Hosps. v. Schweiker,* 691 F.2d 808 (6th Cir. 1982), *reh'g denied,* 708 F.2d 199 (6th Cir. 1983).

The regulations restricting reimbursement of bad debts and charity allowances to those bad debts and charity allowances arising from a Medicare recipient's failure to pay outstanding medical care costs and characterizing bad debts and charity allowances as reductions in revenue rather than operating costs are not unreasonable. They neither conflict with nor frustrate the Congressional policies underlying section 1395x(v)(1)(A).

IV.

In the hospitals' final challenge to 42 C.F.R. § 405.420, they contend that Reg. Sec. 405.420 violates the Fifth Amendment due process clause. They contend that the Secretary has denied them just compensation and argue that even public service corporations may not be compelled to operate at a loss.

The just compensation to which the hospitals are entitled is just compensation for providing health care services for Medicare recipients, not just compensation for operating a health care facility. As noted above, Reg. Sec. 405.420 adequately compensates for services to Medicare

patients, and the Act neither requires nor permits more. Moreover, Reg. Sec. 405.420 does not compel any hospital to operate at a loss. The Medicare Act does not require any provider to render free services, nor does it restrain any provider from instituting measures to reduce its volume of bad debts.

Finally, participation in the Medicare program is wholly voluntary. If any provider fears that its participation will drive it to insolvency, it may withdraw from participation.

> The hospital's argument might well prove persuasive if participation in the Medicare program were mandatory. However, Medicare is a federally sponsored insurance program for the aged and disabled, 42 U.S.C. § 1395c, and provider participation is voluntary, 42 U.S.C. § 1395cc. Providers who opt not to participate are free to serve persons not covered by Medicare and those potential Medicare recipients who are willing to forego Medicare benefits for the services provided. As a practical matter, perhaps a few of those persons eligible for Medicare would choose a non-participating hospital, but the fact that practicalities may in some cases dictate participation does not make participation involuntary. Even those hospitals that have an obligation to participate in the Medicare program because of their receipt of funds under the Hill-Burton Act, 42 U.S.C. § 291; 42 C.F.R. § 124, made a voluntary choice to accept both the obligations and the benefits of Hill-Burton funding. *St. Francis Hosp. Center v. Heckler,* 714 F.2d 872, 875 (7th Cir. 1983), *cert. denied,* 465 U.S. 1022 (1984).

The hospitals finally appear to contend, however, that participation in the Medicare program is not truly voluntary because, they argue, they must participate in order to maintain their tax-exempt status. Even if the hospitals have correctly characterized the requirements for tax-

exempt status, we do not think that requirement affects either the voluntariness of their participation or the absence of any obligation by the federal government to allay a part of their financial burden resulting from bad debts and acts of charity. The decision to seek tax-exempt status, like the decision to accept Hill-Burton funds, is purely voluntary and any obligations are as freely accepted as the benefits.

AFFIRMED.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

No. C-1-83-622

BETHESDA HOSPITAL, ET AL.,

Plaintiffs,

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendant.

MEMORANDUM OPINION

Filed April 30, 1985

SPEIGEL, J.:

INTRODUCTION

In this action, plaintiffs challenge the validity of an administrative regulation governing reimbursement of malpractice insurance costs associated with the care of Medicare patients. The following issues are raised: 1) Whether the Provider Reimbursement Review Board (PRRB) erred in concluding that it lacked jurisdiction over the claims of plaintiffs who self-disallowed malpractice insurance costs? 2) Is the challenged regulation invalid under the Administrative Procedure Act (APA) because of deficiencies in either the Notice of Proposed Rule Making or the Basis and Purpose statement accompanying the regulation in final form? 3) Is the challenged regulation violative of the APA as arbitrary and capricious, an abuse of

discretion or otherwise not in accordance with law? 4) Is the challenged regulation invalid because it is inconsistent with the Medicare Act?

Having reviewed the administrative record and the filings by counsel, and having heard the able arguments of counsel, we reach the following conclusions: 1) The PRRB erred in concluding that it lacked jurisdiction over the claims of the health care providers who "self-disallowed" the malpractice insurance costs; 2) the challenged regulation is violative of the APA in two respects: a) the regulation in final form was not accompanied by an adequate statement of basis and purpose; and b) the issuance of the regulation, based upon the data on which the Secretary relied, was arbitrary and capricious. We do not rule on the issue of whether the challenged regulation is invalid because of alleged inconsistency with the Medicare Act.

I. Factual Background

This case involves a challenge to the new method for reimbursement to health-care providers of malpractice insurance costs associated with the treatment of Medicare patients. The new Malpractice Rule was promulgated by the Department of Health and Human Services in 1979, and is codified at 42 C.F.R. § 405.452(b)(1)(ii) (1984).

The new Malpractice Rule is a marked departure from the previous method of calculating malpractice insurance costs associated with care of Medicare patients. The old approach lumped malpractice insurance costs into the category of General and Administrative costs (G&A costs). G&A costs include a variety of indirect costs associated with patient care. The old regulations provided for application of the provider's overall Medicare utilization ratio to allocate the G&A costs between Medicare and non-Medicare patients. The utilization ratio is the ratio of Medicare patients to the total patient population of the provider hospital.

The challenged regulation, specifically excepts malpractice insurance costs from the category of G&A costs, and thus, abandons the previous approach entirely. Malpractice insurance costs now constitute a separate category of health care costs. The extent to which Health and Human Services will reimburse the provider for malpractice insurance costs is "based on the dollar ratio of the provider's Medicare paid malpractice losses to its total paid malpractice losses for the current costs reporting period and the preceding 4-year period." 42 C.F.R. § 405.452(b)(1)(ii). If a provider has paid no malpractice claims within the applicable five-year period, it is reimbursed at the "national average" ratio of 5.1 per cent. This formula does not consider the Medicare utilization ratio of the provider.

Plaintiffs are providers of hospital services in the State of Ohio who mount this group challenge to the new Malpractice Rule. Of this group, all but two providers have undisputedly perfected their claim to judicial review in this Court. However, the Secretary seeks dismissal of the claims of Bethesda and Deaconess Hospitals, alleging, that this Court lacks jurisdiction over their claims (*see* docs. 37, 43). This jurisdictional issue is best addressed at the outset.

Plaintiffs Bethesda and Deaconess differ from other plaintiffs in that they did not file a claim with the fiscal intermediary[1] for reimbursement of malpractice insurance costs allowable under the old rule but now excludable under the new rule. Instead, Bethesda and Deaconess filed their cost reports with the fiscal intermediary in compliance with the new Malpractice Rule, and hence "self-disallowed" reimbursement for the additional portion of malpractice insurance costs allowable under the old rule.

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[1] The fiscal intermediary is a private entity which, under contract with the Department of Health and Human Services, performs a major administrative role in the operation of the Medicare program. See discussion pp. 11-13 *infra*.

Consequently, the PRRB concluded that, under the statutory administrative review scheme, 42 U.S.C. § 1395oo(a)-(f), it lacked jurisdiction over their appeal from the final determination of the fiscal intermediary because Bethesda and Deaconess made no claim for reimbursement to the intermediary (doc. 43, attachment A).

II. Jurisdictional Issues – "Self-disallowed Costs"

The relevant portions of the administrative review scheme are as follows:

> Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g)(2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if –
>
> (1) such provider –
>
> > (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payments may be made under this subchapter for the period covered by such report,
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> • • • •

> > (2) the amount in controversy is $10,000 or more, and
> >
> > (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

42 U.S.C. § 1395oo(a)(1)-(3).

> A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

42 U.S.C. § 1395oo(d).

The precise issue before us is whether the malpractice insurance costs disclosed on the cost reports by Bethesda and Deaconess but not claimed by those providers as reimbursable costs are "matters covered by such cost reports" over which the PRRB has jurisdiction to review within the meaning of § 1395oo(d).

As evident from the quoted provisions of the statute, section 1395oo contemplates that the PRRB may conduct an adminstrative review of the intermediary's final decision. Perhaps less obvious but nevertheless evident is the legislative intent that the PRRB review need not be limited to costs claimed by the provider to the intermediary in the cost report. Consequently, we conclude that the PRRB erred in concluding that it lacked jurisdiction over the claims of Bethesda and Deaconess Hospitals.

The administrative review scheme contemplated by the statute is as follows: A cost report is submitted first to the fiscal intermediary. The fiscal intermediary determines reimbursement based upon the cost report. If the provider is dissatisfied with the final determination of the fiscal intermediary, and the amount in controversy is greater than or equal to $10,000.00, and the provider files a request for a hearing within 180 days, then the matter is properly subject to PRRB review. PRRB may then pass upon the final determination of the fiscal intermediary with respect to the cost report and make revisions on matters covered by the cost report.

A long established rule of statutory construction is that the words in the statute are to be given their ordinary and intended meaning. *See, e.g., Old Colony Ry. Co. v. Comm. of Internal Revenue*, 284 U.S. 552, 560 (1932) and cases cited therein. Applying this principle to section 1395oo(d), a requirement of an overt claim for reimbursement to the fiscal intermediary as a condition precedent to PRRB review is implicit at best, and in apparent contradiction to the broad grant of authority to the PRRB to revise "matters covered by [the] cost report even though such matters were not considered by the intermediary in making such final determination." 42 U.S.C. § 1395oo(d). However, where case authority exists, we hesitate to base our decision exclusively upon the language of the statute.

Section 1395oo has engendered considerable litigation; however, in the interests of brevity and clarity of thought, we limit our discussion of the statute to the decisions of the Sixth, Seventh, and D.C. Circuit Courts of Appeal.

At issue in *St. Mary of Nazareth Hospital Center v. Department of Health and Human Services*, 698 F.2d 1337 (7th Cir. 1983), *cert. denied*, 104 S. Ct. 107 (1983) (hereinafter *St. Mary*) was whether personal telephones were "personal comfort items," and hence, whether costs associated with such phones were therefore not subject to reimbursement. *St. Mary* included the incidental issue of the PRRB's jurisdiction over claims of one provider who had "self-disallowed" the telephone costs. In a decision based largely upon the language of the statute the Seventh Circuit interpreted section 1395oo(d) as a broad grant of jurisdiction to the PRRB to "consider matters outside cost reports." 698 F.2d at 1337. Thus the Seventh Circuit concluded that the PRRB had jurisdiction over the self-disallowed costs and proceeded to the merits of the claim.

The Sixth Circuit has arguably taken a more restrictive view of the jurisdictional grant of authority to the PRRB contained in section 1395oo, at least where the costs claimed in the PRRB appeal were not included in the cost report in any fashion. In *Saline Community Hospital Association v. Secretary of Health and Human Services*, 744 F.2d 517 (6th Cir. 1984), health care providers sought to amend their 1979 cost reports to add claims for return on net-invested-equity capital—costs which had never been included on the 1979 cost reports in any fashion. The PRRB denied jurisdiction. Judicial review at the district court level proceeded over two motions to dismiss, and the Secretary ultimately prevailed on the merits. On appeal, the Sixth Circuit held that the costs in issue were improperly tendered as amendments since the providers had never included them in the cost reports, and therefore, the PRRB was correct in denying jurisdiction. *Id.* at 520. The

Court also held that the only issue properly before the district court was whether the PRRB erred in concluding that it lacked jurisdiction, and that the trial court should not have reached the merits of the providers' claims. *Id.* at 521.

While instructive, *Saline* is not entirely on point. It is not a self-disallowance case. Therefore, it does not address the issue of the PRRB's jurisdiction over costs disclosed on the cost report but not actually claimed before the fiscal intermediary as reimbursable costs.

We also have the benefit of two D.C. Circuit Court of Appeals decisions. *Athens Community Hospital, Inc. v. Schweiker,* 743 F.2d 1 (D.C. Cir. 1984) (*Athens II*) *modifying Athens Community Hospital, Inc. v. Schweiker,* 686 F.2d 989 (D.C. Cir. 1983) (*Athens I*). At issue in *Athens I and II* were a provider's claims for income tax costs and stock option costs associated with providing health care. Interpreting the stock option costs as matters not covered by the cost reports, and the income tax expenses as self-disallowed costs at best, the Court concluded that the PRRB was correct in concluding it had no jurisdiction because the intermediary was never given the opportunity to rule on the costs in issue. *Id.* at 10. In so holding, the Court through Judge Bork developed a useful, analytical construct for determining the breadth of the jurisdictional grant contained in section 1395oo(d).

Judge Bork views section 1395oo as containing two separate jurisdictional grants to the PRRB. First, it gives the PRRB the "power to affirm, modify or reverse final determinations of the fiscal intermediary with respect to the cost report." 42 U.S.C. § 1395oo(d). Second, PRRB is given the power "to make other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination." *Id.* Satisfaction of either provision vests jurisdiction in the PRRB. 743 F.2d at 4.

The D.C. Circuit acknowledged the difficulty in reconciling these two jurisdictional grants and recognized that these grants permit of a variety of different readings. The Court thereafter suggested that these readings fall into three general categories. The first category contemplates that the PRRB has jurisdiction only over those costs specifically claimed for reimbursement in the cost report presented to the fiscal intermediary. The second category considers the PRRB's jurisdiction to extend to those items disclosed to the fiscal intermediary in or with the cost report. The third category views the PRRB's jurisdiction as covering matters not disclosed to the intermediary through the cost report, but asserted for the first time to the PRRB on appeal from the fiscal intermediary's final determination. *Id.* at 4-5.

It is readily apparent that the first and third categories do not admit to considerations of degree. The first category permits the PRRB to review only those items specifically claimed before the fiscal intermediary. The third category permits any costs to be claimed as reimbursable before the PRRB. One category is precisely limited, the other category is all inclusive. Neither requires further interpretation. In contrast, the middle category, focusing as it does on "disclosure," admits to a large degree of interpretation. Indeed, as the D.C. Circuit recognized, a disclosure rule might include a reasonableness standard which would include as adequately disclosed anything the fiscal intermediary reasonably should have known. 743 F.2d at 4-5.

Following this discussion, the D.C. Circuit suggested that

> "the only . . . way of reading the statute that does give effect to both clauses of section 1395oo(d) . . . is to interpret the statute as allowing the PRRB to revise the aspects of the reimbursement calculation not actually contested by the provider, and possibly not

> considered by the intermediary (because not claimed for reimbursement by the provider), when such revision is necessary to accommodate other PRRB revisions of matters that were claimed by the provider, decided adversely by the intermediary, and then contested by the provider to the PRRB. The provider, however, is allowed to appeal only such adverse decisions of the intermediary.

Id. at 9.

In effect, the D.C. Circuit has implemented a nexus requirement, limiting the PRRB's jurisdiction over those matters not specifically addressed by the fiscal intermediary to claims which are "necessary to accommodate" revisions of any claims specifically asserted before the fiscal intermediary. However, the D.C. Circuit did not endeavor to further define the nexus requirement.

We respectfully decline to adopt the D.C. Circuit's nexus test. There is no such nexus requirement in the language of the statute. Indeed, the parenthetical in the statute providing for "revisions adverse to the provider of the services" seems to be inconsistent with the nexus requirement. 42 U.S.C. § 1395oo(d). For if such a requirement existed, this parenthetical would necessarily be too broad. Under the nexus rule, the PRRB could make revisions adverse to the provider of the services only where such revisions were necessary to accommodate items specifically claimed before the fiscal intermediary. This reasoning is contrary to the language of the parenthetical, and could produce the anamolous result of the fiscal intermediary making an error in favor of the provider and an unrelated error in favor of the Secretary. On appeal of the adverse determination, the nexus rule would vest the PRRB with jurisdiction only over the error adverse to the provider, and the PRRB would have no power to correct the error made in favor of the provider, even though all facts and figures necessary to make such correction were

included on the original cost report. We do not think that this result nor the reasoning which leads to this result reflects the intention of Congress in enacting this administrative review scheme.

Our conclusion is based in part on H. Rep. No. 92-231, *reprinted in* 1972 U.S. Code Cong. & Admin. News. 92nd Cong., 2d Sess., 4989, 5094-5095. In this report, Congress envisioned the review process as follows:

> [A]ll decisions by the board [PRRB] would have to based upon the record made at such hearing [before the board], which may include any evidence submitted by the Department. Such evidence would include the evidence or record considered by the intermediary. Based upon examination of *all* the evidence, the Provider Reimbursement Review Board may find in whole or in part for the provider or the Government (*including a finding based upon the evidence before it that the provider owes sums in addition to the amount raised in the appeal*). (emphasis added)

It is clear from this parenthetical that Congress intended the PRRB to have the final say on reimbursable costs which were included in the evidence presented to the intermediary even if such costs were not specifically claimed as reimbursable and hence, not considered by the intermediary.

An examination of the role of the fiscal intermediary in the reimbursement process indicates that Congress naturally might have vested the PRRB with broad powers of review over intermediary determinations. Fiscal intermediaries were first designated in the Social Security Amendments of 1965, P.L. 89-97; 79 Stat. 286 *reprinted in* 1965 U.S. Code Cong. & Admin. News, 89th Cong. 1st Sess., 305. The legislative history of those amendments indicates that the fiscal intermediary was to perform a "major administative role," as a private entity under contract with the administrative agency, in the administration of

the Medicare program. The specific powers and responsibilities of the fiscal intermediary contemplated by Congress were to determine the amount of payments due providers upon presentation of the providers' claims and to make such payments; to serve as a conduit of information between the providers and the agency; and to provide consultative services; to assist providers to establish and maintain necessary records; and to assist providers in meeting the qualifications requirement for participation in the Medicare program. Intermediaries could also be employed to audit provider records and to perform related functions. S. Rep. 404 *reprinted in* [1965] U.S. Code Cong. & Admin. News, 89th Cong. 1st Sess. pp. 1943, 1949, 1992-95. Although the 1972 amendments set up the administrative review scheme now under consideration (*see* p. 11 *supra*), the 1972 amendments contained no indication of any major change in the function of fiscal intermediary. Thus the function of fiscal intermediary is and always has been that of an administrator, informational conduit, and auditor.

We acknowledge that some interpretation of agency regulations is implicit in the job of fiscal intermediary. But aside from such implicit interpretative power, the legislative history indicates no vesting of deliberative authority in the fiscal intermediary. Thus it is only natural that Congress would not envision the unchallenged determinations of the fiscal intermediary to be beyond review by the agency absent some connection with a challenged claim.

The absence of any large measure of deliberative authority in the fiscal intermediary's function undercuts the Secretary's argument in another respect. By arguing that the PRRB has no jurisdiction over claims which were not presented to the fiscal intermediary, the Secretary advances what is in essence an exhaustion of administrative remedies argument. On the facts of this case, requiring providers to submit the claims involved to the fiscal inter-

mediary is particularly inappropriate. First, the malpractice rule requires no interpretation. Both the old and new rules are mathematically precise and submit easily to mechanical application. Second, the fiscal intermediary is not authorized to grant the relief sought. Plaintiffs here are not challenging the application of rule to particular facts. Rather, they challenge validity of the rule itself because of alleged illegality in its inception and its asserted inconsistency with the Medicare Act. We think it is clearly beyond the role of the fiscal intermediary, as a prviate agency operating under contract with the Department of Health and Human Services, to review the legality of a regulation entrusted to it for application. Therefore, as "the exhaustion doctrine contemplates an efficacious remedy," *Humana of South Carolina, Inc. v. Califano,* 590 F.2d 1070, 1081 (D.C. Cir. 1981), (quoting *Wallace v. Lynn,* 507 F.2d 1186, 1190 (D.C. Cir. 1974)), and the fiscal intermediary can provide no meaningful remedy on these facts, we will not infer an exhaustion of remedies requirement where none is explicitly stated by the statute or indicated appropriate by the legislative history.

Based upon the foregoing analysis, we conclude that the grant of authority to the PRRB to review determinations made by the fiscal intermediary contained in section 1395oo(d) is more appropriately limited to those items disclosed in the cost report such that all figures necessary to any calculations are contained in the cost report. Therefore, we conclude that the PRRB erred in concluding that it had no jurisdiction to review Bethesda and Deaconess Hospitals' claims for reimbursement of self-disallowed costs. However, that is the extent of our review. We do not proceed to the merits of plaintiffs' claims as regard Bethesda and Deaconess because of the clear instruction of *Saline,* 744 F.2d 517 at 521.

III. THE VALIDITY OF MALPRACTICE INSURANCE RULE

(A) Additional Factual Background Necessary to a Decision on the Merits

The Notice of Proposed Rule Making (NPRM) was published on March 15, 1979, 44 Fed. Reg. 15,744. The NPRM indicated that a forty-five day period for public comment would be observed as a passage of the rule was being expedited for implementation in fiscal year 1979. *See* "Action Memorandum" Administrative Record Volume 1, Tab 28. This forty-five day comment period represented a departure from Executive Order 12044 which established a sixty day comment period for proposed regulations. 43 Fed. Reg. 12,661 (March 24, 1978).

The rule proposed in the NPRM was justified by an allusion to "a study conducted by an HEW consultant" which indicated that closed malpractice claims involving Medicare patients were generally lower than such claims involving non-Medicare patients. 44 Fed. Reg. 15,745. The NPRM contained no other justification for the agency's conclusion that Medicare was bearing a disproportionate share of malpractice insurance costs. The study mentioned was neither identified nor offered for public perusal. On May 1, 1979, the agency issued a notice reopening the comment period for an additional fifteen days, thereby bringing the notice in compliance with Executive Order 12044 *supra*. 44 Fed. Reg. 25,476.

On June 1, 1979, HEW published the final form of the regulation. 44 Fed. Reg. 31,641-42, codified at 42 C.F.R. § 405.452(b)(1)(ii). The preamble to the final rule acknowledged that "all comments received were against proposal and recommended that [HEW] withdraw it entirely." 44 Fed. Reg. 31,641. There were approximately six hundred comments from interested parties in opposition to the regulation. Administrative Record Vols. 5-8.

The final form of the malpractice rule was published against the recommendation of the Deputy General

Counsel for Regulation Review, Administrative Record Vol. 2, Tab 49, who noted that the preamble was inadequate and poorly written and cautioned that as all comments opposed the proposed regulation, there was a need for careful explanation of the rejection of such comments. *Id.* However, other than acknowledging that all comments received were against the proposed regulation, the agency did not address such comments in significant detail when promulgating the rule in final form. 44 Fed. Reg. 31,641-42.

The study alluded to in the NPRM was identified in the final rule as the Medical Malpractice Closed Claim Study, 1976 performed by Westat, Inc. (hereinafter Westat study). The Westat study consisted of an analysis of malpractice claims closed by nine companies during a four month period in 1976. Administrative Record Vol. 3 at 1-2, 1-3 & 2-1. The authors of the study noted that it was not the purpose of the study to make national yearly estimates. Administrative Record Vol. 3 at 2-5. The study was a census and not a representative sample. *Id.* at 2-9. Specifically, the authors warned that "conclusions must be drawn very cautiously because of the possibility of biased data." *Id.* at 2-3. Also, the authors acknowledged the limitation of the study due to the exlusion of self-insurers. *Id.*

Other weaknesses in the study were documented in the author's summary. Administrative Record Vol. 4, Tab 37. Because of the sample design, the authors concluded that it was "virtually impossible to generalize beyond the sample to annual totals or to national totals . . ." and that there was "no assurance that the sample was in any way representative of hospitals, of physicians, of injuries of geographic regions, of claimants." *Id.* While the plaintiffs' criticisms of the statistical validity of Westat study go far beyond those listed above, we do not address them as those heretofore discussed are sufficient for our decision.

(B) Procedural Challenges

Plaintiffs challenge the malpractice rule both procedurally and substantively. The procedural challenges are based upon the Administrative Procedure Act, Title 5 U.S.C. §§ 551 *et seq.*, §§ 701 *et seq.* The standard for judicial review of the validity of an administrative regulation is whether the Secretary complied with the necessary procedural requirements in promulgating the rule, whether the Secretary acted within the scope of her statutory power, and whether the choice was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). *See Citizens to Preserve Overton Park, Inc. v. Volpe,* 401 U.S. 402, 416-17 (1971). However, the "court is not empowered to substitute its judgment for that of the agency." *Id.* at 416. Nevertheless, judicial deference to the agency's judgment in implementing congressionally enacted statutory policies "cannot be allowed to slip into judicial inertia." *Bureau of Alcohol, Tobacco and Firearms v. Federal Labor Relations Authority,* 104 S. Ct. 439, 444 (1983), (quoting *American Ship Building Co. v. N.L.R.B.*, 380 U.S. 300, 318 (1965)), and Courts "are not obliged to stand aside and rubber stamp their affirmance of administrative decisions that they deem inconsistent with a statutory mandate or that frustrate the congressional policy underlying a statute." *NLRB v. Brown,* 380 U.S. 278, 291 (1965). Finally, "if Congress established a presumption from which judicial review should start, that presumption . . . [is] *against* changes in current policy that are not justified by the rule making record." *Motor Vehicle Manufacturer's Ass'n of the United States, Inc. v. State Farm Automobile Insurance Company,* 103 S. Ct. 2856, 2866 (1983) (emphasis in original). Such is the standard as set forth by Judge Will in *St. James Hospital v. Heckler,* slip op. 83 C2773 at 11-12 (N.D. Ill. Jan. 27, 1984) with which we concur.

1. *Adequacy of the NPRM*

We first address the adequacy of the NPRM. The APA requires public notice of an agency's intention to issue a regulation. A notice must be "sufficient to fairly apprise interested parties of all significant subjects and issues involved." *American Iron and Steel Institute v. EPA,* 568 F.d 284, 291 (3d Cir. 1977), (citing S. Rep. No. 752, 79th Cong., 1st Sess. at 16 (1945)). Notice provisions are intended to provide the opportunity for public participation in the rule making process, *Buckeye Power, Inc. v. EPA,* 481 F.2d 162, 170 (6th Cir. 1973), *cert. denied, sub nom. Tennessee Valley Authority v. EPA,* 425 U.S. 934 (1976), and to inspire agency self-education prior to actual rule making. *American Iron,* 568 F.2d at 291. Notice is also valuable because it develops the record of agency decision-making and hence facilitates judicial review. *Home Box Office, Inc. v. FCC,* 567 F.2d 9, 35 (D.C. Cir. 1977), *cert. denied,* 434 U.S. 829 (1977). Notice is most valuable when it discloses the data upon which the agency proposes the rule. *Connecticut Light and Power Company v. Nuclear Regulatory Commission,* 673 F.2d 525, 530-31 (D.C. Cir.), *cert. denied,* 459 U.S. 835 (1982). *Cf. United States Lines v. Federal Maritime Commission,* 584 F.2d 519 (D.C. Cir. 1978).

From examination of the NPRM at issue here, the agency is in technical non-compliance because of the failure to identify the data upon which it relied—(*i.e.*, the Westat study or any other data for that matter). However, the rule making record indicates that the Westat study reached health care professionals in sufficient number in time to permit development of the rule making record. The Westat study is discussed in detail in the rule making record, and therefore, we will not declare the rule invalid because of this technical non-compliance.

2. *Adequacy of the basis and purpose statement*

We turn next to the adequacy of the basis and purpose statement which accompanied the rule in its final form. A basis and purpose statement is required by 5 U.S.C. § 553(c). *Sierra Club v. Gorsuch*, 715 F.2d 653, 658 n.31 (D.C. Cir. 1983). Section 553(c) provides in pertinent part:

> After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation. After consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a concise general statement of their basis and purpose.

The basis and purpose statement need not be an exhaustive discussion of comments to the agency. *Automotive Parts and Accessories Ass'n v. Boyd*, 407 F.2d 330, 338 (D.C. Cir. 1968). However, the agency must "respond in a reasoned manner to the comments received, to explain how the agency resolved any significant problems raised by the comments, and to show how that resolution lead the agency to the ultimate action." *Action on Smoking and Health v. C.A.B.*, 699 F.2d 1209, 1216 (D.C. Cir. 1983) (quoting *Rodway v. U.S. Department of Agriculture*, 514 F.2d 809, 817 (D.C. Cir. 1975)). Ultimately, "the detail required in a statement of the basis and purpose depends upon the subject of regulation and the nature of the comments received." *Action on Smoking and Health*, 699 F.d at 1216.

In the instant case, the subject of regulation is a rule by which health care providers are reimbursed for malpractice insurance costs. This regulation has considerable economic impact and represents a significant change from previous agency policy. While we do not question the Secretary's authority to depart radically from existing policy, we note that there is a presumption against such

changes, unless they are supported by the rule making record. *Motor Vehicle Manufacturers*, 103 S. Ct. at 2866. This presumption requires the Secretary or Agency to respond in significant detail to serious comments opposing the proposed regulations. Here, we do not view the agency's response as sufficient. On this point we agree with Judge Fullam of the Eastern District of Pennsylvania who stated:

> It would have been a miracle of bureaucratic succinctness had the Secretary managed to reply adequately in two scant columns of Federal Register prose to the six hundred plus comments that occupy five thick volumes of the administrative record. Unfortunately no such miracle has been witnessed by this court.

Abington Memorial Hospital v. Heckler, 576 F. Supp. 1081, 1085-86 (E.D.P.A. 1983) *aff'd* 750 F.2d 242 (3d Cir. 1984).

More disturbing than the brevity of the basis and purpose statement is the content. As Judge Fullam noted, the American Hospital Association and the Hospital Corporation of America, among other commenters, questioned the statistical validity of the Westat study which was the only objective data upon which the regulation was based. *See* Administrative Record Vol. 5, (no tab) p. 9; and Vol. 6 (no tab) p. 5. The preamble to the final rule neither acknowledges nor responds to these criticisms. *See* 576 F. Supp. 1086. Again, as noted by Judge Fullam, the comments included contentions that malpractice insurance costs were not necessarily reflected by claims payments, however, these comments were not addressed by the agency in promulgating the final rule either. *Id.*

In sum, we conclude that the agency has neither responded in a reasoned manner to comments received nor explained how it resolved significant problems raised by these comments. Rather, we are left with the impression that the agency evaded the most significant problems

raised by the comments, *i.e.*, the statistical challenges to the Westat study and the use of the Westat study for purposes other than those for which it was intended. The conclusion is inescapable that the agency violated the APA in failing to include an adequate basis and purpose statement with the regulation in its final form.

3. *Abuse of Discretion*

Plaintiffs also challenge the new malpractice rule under 5 U.S.C. § 706(2)(A). That statute provides that a reviewing court may set aside agency action when found to be "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." *Id.* In short, plaintiffs contend that the Secretary's action in promulgating the new malpractice rule was arbitrary and capricious. The standard of review under section 706(2)(a) has recently been stated as "whether the decision was based upon a consideration of the relevant factors and whether there had been a clear error of judgment." *Motor Vehicle Manufacturers Ass'n,* 103 S. Ct. 2856, 2865, 2867 (1983). The reviewing court should not second guess the agency on technical matters but should "set aside administrative rules for which the record . . . demonstrates a lack of rational basis." *PPG Industries v. Costle,* 630 F.2d 462, 465 (6th Cir. 1980). Reliance on flawed data is properly considered a clear error in judgment at least where the flaws are known to the agency prior to promulgation of the final rule. *Almay, Inc. v. Califano,* 569 F.2d 674 (D.C. Cir. 1977).

In this case we think it is clear that the Secretary relied on flawed data in promulgating the new malpractice rule. The authors of the Westat report stated that "conclusions must be drawn very cautiously because of the possibility of biased data." Administrative Record Vol. 3 at 2-2. Also, in a memorandum to the HEW project officer in charge of the medical malpractice study, the Westat senior analyst stated that it is "virtually impossible to generalize beyond

the sample . . . to annual totals or to national totals. . . ." Beyond that there was no assurance that the sample was in any way representative of [hospitals], of physicians, of injuries, of geographic regions, of claimants. Administrative Record Vol. 4, Tab 37. Given these comments by the authors and the fact that the Secretary then used the Westat study as a basis for implementing the regulation, and, extrapolated from the study the "national average" of 5.1%, it is abundantly clear that the agency proceeded to use the Westat study in the very manner the authors cautioned against. Under such circumstances we have no hesitation in holding the implementation of the new Medicare malpractice reimbursement rule a clear error of judgment.

(C) Substantive Challenge

We do not decide whether the new malpractice rule is in violation of the substantive provisions of the Medicare Act as plaintiffs contend. As the procedural issues are dispositive, it is unnecessary for us to reach this issue. Furthermore, we do not presume to determine any inconsistency based on what we view as the significantly flawed factual basis upon which the agency premised the challenged rule.

IV. CONCLUSION

We recognize that deferential consideration should be given regulations promulgated by the Secretary, and that courts should be cautious to overturn such regulations. *NLRB v. Bell Aerospace Co. Division of Textron, Inc.,* 416 U.S. 267, 274-75 (1974). Having exercised that caution, we must nevertheless invalidate the regulation challenged in this action. We note that in holding the regulation invalid we are in accordance with the consid-

erable weight of authority.[2]

In accordance with the foregoing, plaintiffs' motion for summary judgment is hereby granted and defendant's

[2] The new Medicare Malpractice Reimbursement Rule has been invalidated in at least eighteen cases. *Arkansas Methodis Hospital v. Heckler*, Slip Op. J-C-83-106 (E.D. Ark. Nov. 2, 1984); *East Jefferson General Hospital v. Heckler*, Slip Op. 83-4107-C (E.D. La. Oct. 19, 1984); *St. Anthony Regional Hospital v. Heckler*, No. C84-37 (N.D. Iowa Oct. 12, 1984); *Parkway Medical Center v. Heckler*, Slip Op. 83-1700 (S.D. Fla. Sept. 24, 1984); *Mercy Medical Center v. Heckler*, No. 3-82 Civ. 1724 (D. Minn. Aug. 17, 1984); *Menorah Medical Center v. Heckler*, No. 83-0822-CV-W-4 (W.D. Mo. July 26, 1984); *Metropolitan Hospital, Inc. v. Heckler*, Slip Op. C-83-502-A (N.D. Ga. June 25, 1984); *DeSoto General Hospital v. Heckler*, Civil Action 83-1050-B (M.D. La. June 20, 1984); *Alexandria Hospital v. Heckler*, No. 83-0233-R (E.D. Va. May 4, 1984); *St. Joseph's Hospital, Tuscon v. Heckler*, Slip Op. 82-781 (D. Ariz. April 24, 1984); *Lloyd Noland Hospital and Clinic v. Heckler*, Slip Op. CV-83-PT-0868-S (N.D. Ala. April 5, 1984); *Bedford County Memorial Hospital v. Heckler*, Slip Op. 83-836-A (W.D. Va. March 28, 1984); *Humana of Illinois, Inc.*, Slip Op. 83-3061 (C.D. Ill. March 2, 1984), *appeal docketed*, No. 894-1727 (7th Cir. April 30, 1984); *Albany General Hospital v. Heckler*, Slip Op. 83-851-FR (D. Ore. March 2, 1984), *appeal docketed*, No. 84-3865 (9th Cir. June 6, 1984); *St. James Hospital v. Heckler*, Slip Op. 83C2773 (N.D. Ill. Jan. 27, 1984); *Chelsea Community Hospital v. Heckler*, Slip Op. 83 CV-6126-AA (E.D. Mich. Dec. 20, 1983); *Mt. Carmel Mercy Hospital v. Heckler*, Slip Op. 82-74193 (E.D. Mich. Nov. 30, 1983); *Abington Memorial Hospital v. Heckler*, 576 F. Supp. 1081 (E.D. Pa. 1983) *aff'd* 750 F.2d 252 (3d Cir. 1984).

To our knowledge, the malpractice rule has been upheld in four cases. *Humana of Aurora, Inc. v. Heckler*, No. 83-7-70 (D. Colo. Sept. 19, 1983), *rev'd and rem'd*, 753 F.2d 1579 (10th Cir. 1985); *Walter O. Boswell Memorial Hospital v. Heckler*, 573 F. Supp. 884 (D.D.C. 1983) *rev'd and rem'd*, slip op. 83-2223 (D.C. Cir. Nov. 30, 1984); *Cumberland Medical Center v. Heckler*, 578 F. Supp. 39 (M.D. Tenn. 1983) *appeal docketed*, No. 83-5549 (6th Cir. Aug. 9, 1983); *Athens Community Hospital v. Heckler*, 565 F. Supp. 695 (C.D. Tenn. 1983), *appeal docketed*, No. 83-5546 (6th Cir. Aug. 5, 1983). As reflected by the subsequent history above, two of these four cases have been reversed and remanded.

motion for summary judgment is hereby denied. The parties will brief the issues of the appropriateness of relief according to the normal briefing schedule set out by the local rules of this Court. Plaintiffs' brief is due within thirty days of the date of this Order.

SO ORDERED.

/s/ S. ARTHUR SPIEGEL

S. Arthur Spiegel
United States District Judge

Department of Health and Human Services
Provider Reimbursement Review Board
793 Elkridge Landing Road
Linthicum, Maryland 21090

Refer to:
JB:81-229G
FEB. 18, 1983
Certified Mail

Location:
Airport Investment Building
Room 245, South Plaza
Telephone: 301-859-5820

Margaret Manning, Esquire
Ober, Grimes & Shriver
1600 Maryland National Bank Building
Baltimore, Maryland 21202

Dear Ms. Manning:

Re: Ohio Malpractice Group Appeal, Case No. 81-229G

The Board has reviewed the record in the above-captioned case and finds there is no jurisdictional authority concerning the malpractice issue for the providers listed on the enclosure in the Ohio Malpractice Group Appeal. This finding is based upon the fact that the malpractice issue was not raised in the Prover's cost report(s); nor have any amended cost report(s) been accepted by the Intermediary on this issue; nor have any Notices of Program Reimbursement (NPR's) included any denials or adjustments of cost(s) pertaining to the subject issue.

Pursuant to the controlling law and regulations (42 USC section 1395oo and 42 CFR 405, subpart R), the Board is empowered to review and hold hearings concerning final determinations of fiscal intermediaries (i.e., NPR) regarding Medicare provider cost reimbursement. The jurisdictional requirements to secure a Board hearing are set forth in 42 USC section 1395oo(a) and (b).

Title 42 USC section 1395oo provides:

> "(a) *Any provider of services which has filed a required cost report* within the time specified in regulations *may obtain a hearing with respect to such cost*

> report by a Provider Reimbursement Review Board (hereinafter referred to as the 'Board') which shall be established by the Secretary in accordance with subsection (h), *if*–
>
> (1) such provider –
>
> (A) *is dissatisfied with a final determination* of the organization serving as *its fiscal intermediary* . . . as to the amount of total program reimmbursement due the provider for the period *covered by such report*, . . .
>
> (2) the *amount in controversy* is $10,000 or more, and
>
> (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination. . . .
>
> (b) The provisions of subsection (a) shall apply to any group . . . if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more." (Emphasis added)

The regulation, 42 CFR 405.1839(a), provides the methodology of determining the $10,000 amount in controversy as follows:

> "The $10,000 *amount in controversy* will be computed by deducting the adjusted total reimbursable program costs from the total reimbursable cost . . . *claimed* by the provider." (Emphasis added)

The cited statutory provisions clearly entitle a provider to a Board hearing only with respect to a cost report which was filed in compliance with the rules and regulations of the Secretary. The Board's jurisdiction is limited to issues when the provider ". . . is dissatisfied with a final determination (NPR) of its intermediary . . ." on matters covered by such filed cost report; and the request for hearing is made within 180 days of the NPR. The statutory phrases ". . . dissatisfied with a final determination of its

intermediary . . .", ". . . amount in controversy . . .", and ". . . covered by such cost report . . ." certainly indicate that a provider must have made an overt disclosure (notice) of its posture on a particular issue which ordinarily would be evidenced by claiming reimbursement for the particular item on the cost report.

The regulations clearly require that, as a condition precedent, the provider must have claimed the cost in its filed cost report to give rise to any controversy. Without any notice of a claimed cost on a cost report, the intermediary is precluded from considering the matter and making any final determination for that particular item which especially applies to self-disallowed costs. The intermediary's final determination is a statutory prerequisite for Board (or judicial) jurisdiction. Thus, the Board's jurisdiction flows from the intermediary's NPR with respect to the filed cost report, and the disputes arising from costs claimed in the cost report.

The provider's entitlement to a hearing is conditioned upon the three subsections immediately following the word "IF" of the basic section—see 42 USC 1395oo(a) cited above. Accordingly, the statutory language *does require* dissatisfaction with the intermediary's final determination and for a controversy to exist. When the provider files a cost report, the particular cost must be claimed therein or state its claim and disclose its position on an issue so the intermediary can consider and make a final determination which was not done in this case. This is essential to Board jurisdiction.

The statute does not entitle a provider to claim additional reimbursement for a particular cost reporting period after filing its cost report nor after receiving the intermediary's final determination (NPR). However, once a cost report is filed, the regulations provide that any amendments to the cost report ". . . may be permitted or required as determined by the Health Care Financing Administration, ..." (42 CFR section 405.453(f)) HCFA

policy instructions stated in Pt. 2—Part A Intermediary Manual, section 2631.2 (HIM-13-2), contains the criteria in the limited situations where the intermediary may accept an amended cost report. Once an intermediary has issued a final determination (NPR) regarding a provider's filed cost report, a cost report may only be amended if the intermediary "reopens" its final determination. Accordingly, the reopening provisions of the regulations are controlling, 42 CFR section 405.1885(a), and jurisdiction for such reopenings rests exclusively with that administrative body that rendered the last determination (which in this case was the intermediary) (42 CFR section 405.1885(c)). (See *Athens Community Hospital, Inc., et. al., v. Richard S. Schweiker, Secretary of Health and Human Services,* United States Court of Appeals for the District of Columbia Circuit, No. 81-1807, August 27, 1982.)

The Athens court (supra) stated:

> "Reopening is thus allowed only to hear new evidence—not new claims. Moreover, under 42 CFR section 405.1885(c), jurisdiction to reopen "rests exclusively with that administrative body that rendered the last determination or decision"; in other words, if the fiscal intermediary decides not to reopen, the decision is not appealable to the PRRB."

Section 405.1885(c) of the regulations states that ". . . jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision." Section 405.453(f) also provides that ". . . amended cost report information which has been previously submitted by a provider *may be permitted* or required as determined by the Health Care Financing Administration." The Medicare Bureau's (formerly Bureau of Health Insurance) policy (HIM 13, Part 2) further adds "Whether or not the Intermediary will reopen a determination . . . which is otherwise final, will depend upon whether new and material

evidence has been submitted, or a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations, or guidelines."

The above authorities provide: (1) that the acceptance of an amended cost report is within the discretion of the intermediary, and (2) that once an NPR has been issued, then the reopening (including through an amended cost report) is within the exclusive jurisdiction of the intermediary which is not appealable per se.

The Board's jurisdiction flows from the cost report or amended cost report and the related NPR or revised NPR. There must have been a claim on the cost report or amended cost report that ultimately gives rise to the disagreement. Thus, Board jurisdiction is limited to those cases in which a provider has claimed a reimbursement amount and the intermediary has denied that claim in full or in part. Title 42 USC 1395oo(d) provides:

> "The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make other revisions on matters *covered by such cost report* (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination."

The Athens Court stated:

> "This provision is clearly limited to revisions of matters covered by the original cost report and does not authorize the Board to consider new claims. Such a conclusion is reinforced by 42 USC section 1395oo(a) which similarly limits PRRB review to matters raised by the original cost report."
>
> "Nor do the Medicare regulations provide a basis for such review. The language in 42 CFR section 405.1869 is virtually identical to that in 42 USC section 1395oo(d) . . . and the scope of the regulation is accordingly limited to 'matters covered by (the original) cost report.' "

It is equally clear, therefore, that the Board, in reaching a decision, may go beyond just the matters which were considered by the intermediary in making its final determination but that such expansion is limited to "matters covered by such cost report." A number of providers have asked that they be allowed to introduce into Board hearings various additional reimbursement items which they had never claimed and which their intermediaries had, therefore, never adjusted or disallowed. Neither the law nor the Board's exercise of this section 1395oo(d) authority in limited cases contemplated any substantial proliferation. No consideration will be given to any request for a hearing which does not comply with the foregoing minimal requirements and no expansion of the scope of the appeal or the hearing will be allowed to include any other issue or amount not originally claimed. This determination is subject to the provisions of 42 USC 1395oo(f).

Board Members Participating:

Thomas M. Tierney
James Houdek, Jr., CPA
Bette A. Kraus
Paul Morton Ganeles, CPA
Richard A. Dudgeon, CPA

FOR THE BOARD:

/s/ THOMAS M. TIERNEY
Thomas M. Tierney
Chairman

Enclosure

cc:
Irwin Cohen, Esquire, Attorney Advisor's Office
Mr. John P. Ruocco, Blue Cross and Blue Shield Ass'n.
Mr. Louis C. Schwienher, Hospital Care Corporation
Mr. Vito Checchio, Blue Cross of Central Ohio
Mr. Donald L. Reed, Blue Cross of Northwest Ohio
Mr. Edward S. Shamrock, Blue Cross of Northeast Ohio

ISSUE: COSTS OF MALPRACTICE INSURANCE

Number	Provider Name	Date of NPR	Date of Hearing Request	Cost Reporting Period-FYE	Fiscal Intermediary	Amount of Medicare Reimbursement In Controversy	Audit Adjustment Number
36-0193	Bethesda Hospital	04/28/82	09/09/82	12/31/80	Blue Cross of Central Ohio	141,381	
36-0127	Memorial Hospital of Geneva	05/21/82	08/20/82	12/31/80	Blue Cross of N.E. Ohio	9,000	•
36-0021	St. Joseph River-side Hospital	02/19/82	01/19/83••	12/31/80	Hospital Care Corporation	[2,035]	•
36-0145	Elyria Memorial Hospital	04/23/82	09/09/82	12/31/80	Blue Cross of N.E. Ohio	16,752	•
36-0038	Deaconess Hosp.	06/29/82	01/19/83	12/31/80	Hospital Care Corporation	61,970	•